

# **Veterans Affairs: A Preliminary Analysis of the FY2013 Budget Proposal**

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## Summary

The Department of Veterans Affairs (VA) provides a range of benefits and services to veterans who meet certain eligibility criteria. These benefits and services include hospital and medical care, disability compensation and pensions, education, vocational rehabilitation and employment services, assistance to homeless veterans, home loan guarantees, administration of life insurance as well as traumatic injury protection insurance for servicemembers, and death benefits that cover burial expenses.

This report provides a preliminary analysis of the President's budget request for FY2013 for the programs administered by the VA. For FY2013, the Administration is requesting approximately \$140.3 billion for the VA, an increase of \$13.4 billion over FY2012 budget authority. This amount includes approximately \$64.0 billion in discretionary funds and approximately \$76.4 billion in mandatory funding.

The FY2013 budget request for VA medical care programs is \$56.3 billion, with a FY2014 request of advance appropriations of \$54.5 billion.

This report is not an exhaustive discussion of VA's budget request for FY2013. A full CRS report on FY2013 VA budget and appropriations issues is planned after initial congressional consideration of appropriations legislation.

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## Introduction

The Department of Veterans Affairs (VA) provides a range of benefits and services to veterans who meet certain eligibility criteria. These benefits and services include, among other things, hospital and medical care, disability compensation and pensions,<sup>1</sup> education,<sup>2</sup> vocational rehabilitation and employment services,<sup>3</sup> assistance to homeless veterans,<sup>4</sup> home loan guarantees,<sup>5</sup> administration of life insurance as well as traumatic injury protection insurance for servicemembers,<sup>6</sup> and death benefits that cover burial expenses.<sup>7</sup>

The department carries out its programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for health care services and medical and prosthetic research programs. The Veterans Benefits Administration (VBA) is responsible for, among other things, providing compensation, pensions, and education assistance. The National Cemetery Administration (NCA)<sup>8</sup> is responsible for maintaining national veterans cemeteries; providing grants to states for establishing, expanding, or improving state veterans cemeteries; and providing headstones and markers for the graves of eligible persons, among other things. The BVA reviews all appeals made by veterans or their representatives for entitlement to veterans' benefits, including claims for service connection, increased disability ratings, pensions, insurance benefits, and educational benefits, among other things.

This report provides a preliminary analysis of the President's budget request for FY2013 for the programs administered by the VA. The information provided in this report is based on the President's budget proposal provided to Congress on February 13, 2012.

The report begins with a brief introduction to the department's budget. Next, it provides funding levels requested by the President for FY2013 for VA health related programs. This is followed by a discussion of funding levels requested for mandatory programs and administration, including programs such as construction of VA facilities and information technology. This not an exhaustive discussion of VA's budget request for FY2013.

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<sup>1</sup> For more information on programs, see CRS Report RL34626, *Veterans' Benefits: Benefits Available for Disabled Veterans*, by Christine Scott, Carol D. Davis, and Libby Perl; and CRS Report RS22804, *Veterans' Benefits: Pension Benefit Programs*, by Christine Scott and Carol D. Davis.

<sup>2</sup> For a discussion of education benefits, see CRS Report R40723, *Educational Assistance Programs Administered by the U.S. Department of Veterans Affairs*, by Cassandra Dortch.

<sup>3</sup> For details on VA's vocational rehabilitation and employment, see CRS Report RL34627, *Veterans' Benefits: The Vocational Rehabilitation and Employment Program*, by Christine Scott and Carol D. Davis.

<sup>4</sup> For detailed information on homeless veterans programs, see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

<sup>5</sup> For details on the home loan guarantee program, see CRS Report RS20533, *VA-Home Loan Guaranty Program: An Overview*, by Bruce E. Foote.

<sup>6</sup> For more information on insurance programs, see CRS Report R41435, *Veterans' Benefits: Current Life Insurance Programs*, by Christine Scott.

<sup>7</sup> For more information on burial benefits, see CRS Report R41386, *Veterans' Benefits: Burial Benefits and National Cemeteries*, by Christine Scott.

<sup>8</sup> Established by the National Cemeteries Act of 1973 (P.L. 93-43).

## The Department of Veterans Affairs Budget

To provide some context to the discussion that follows, this section briefly introduces the various accounts that fund the department. The VA's budget is composed of both mandatory and discretionary spending accounts.<sup>9</sup> Mandatory funding supports disability compensation, pension benefits, education, vocational rehabilitation, life insurance, and burial benefits, among other benefits and services.<sup>10</sup> Discretionary funding supports a broad array of benefits and services with a majority of funding going toward providing medical care to veterans. According to the President's budget documents, in FY2012 the total VA budget authority was approximately \$127.0 billion. The FY2013 budget request for the VA is for approximately \$140.3 billion in budget authority.

The VA's health care program is funded through multiple appropriations accounts that are supplemented by other sources of revenue. The appropriation accounts used to support VA health care programs include (1) medical services, (2) medical administration (currently known as medical support and compliance), (3) medical facilities, and (4) medical and prosthetic research. In addition to the direct appropriations accounts mentioned above, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VA the authority to bill some veterans and most health care insurers for non-service-connected care provided to veterans enrolled in the VA health care system to help defray the cost of delivering medical services to veterans. The Balanced Budget Act of 1997 (P.L. 105-33) gave the VA the authority to retain these funds in the Medical Care Collections Fund (MCCF). The funds deposited into the MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

In 2009, Congress passed the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) that authorized advance appropriations for three of the four accounts that comprise the VHA: medical services, medical support and compliance, and medical facilities. The medical and prosthetic research account is not funded as an advance appropriation, but is funded through the regular appropriations process.<sup>11</sup>

The medical services account funds health care services provided to eligible veterans and beneficiaries in VA's medical centers, outpatient clinic facilities, contract hospitals, state homes, and outpatient programs on a fee basis. The medical support and compliance account funds management and administration of the VA health care system, including financial management. The medical facilities account includes funds for the operation and maintenance of the VA health

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<sup>9</sup> Federal spending is often divided into three categories: discretionary spending, mandatory spending, and net interest. Mandatory spending includes federal government spending on entitlement programs as well as other budget outlays controlled by laws other than appropriation acts. Entitlement programs such as Social Security and Medicare make up the bulk of mandatory spending. Discretionary spending is provided and controlled through appropriation acts (CRS Report RL33074, *Mandatory Spending Since 1962*, by D. Andrew Austin and Mindy R. Levit).

<sup>10</sup> These benefits are considered an appropriated entitlement. The level of spending for appropriated entitlements, like other entitlements, is based on the benefit and eligibility criteria established in law. The amount of budget authority provided in appropriations acts for these specific programs is based on meeting projected spending levels. Because the authorizing legislation effectively determines the amount of budget authority required, the Budget Enforcement Act (BEA) of 1990 (P.L. 101-508) classified appropriated entitlement spending as mandatory (CRS Report RL33074, *Mandatory Spending Since 1962*, by D. Andrew Austin and Mindy R. Levit).

<sup>11</sup> In general, through the annual appropriations process, Congress provides appropriations for the coming fiscal year that begins October 1 of that year. As authorized by P.L. 111-81, Congress provides an advance appropriation for the medical services, medical support and compliance, and medical facilities accounts for the following fiscal year.

care system's capital infrastructure (excluding construction), such as costs associated with utilities, facility repair, laundry services, and groundskeeping.

## The Budget Request for FY2013—Health Care Programs

### Background

The Veterans Health Administration (VHA) operates the nation's largest integrated direct health care delivery system.<sup>12</sup> Although Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are also publicly funded programs, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system could be categorized as a veteran-specific national health care system, in the sense that the federal government owns the medical facilities and employs the health care providers.<sup>13</sup>

The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.<sup>14</sup> As of FY2012, VHA operates 152 hospitals (medical centers), 133 nursing homes, 824 community-based outpatient clinics (CBOCs),<sup>15</sup> 6 independent outpatient clinics, and 300 Readjustment Counseling Centers (Vet Centers).<sup>16</sup> In 2009, VA began a pilot Mobile Vet Center (MVC) program to improve access to services for veterans in rural areas, and the Department has deployed 70 MVCs to date. VHA also operates 10 mobile outpatient clinics.<sup>17</sup>

VHA provides most health care services to eligible veterans through its integrated network of facilities. However, current law authorizes VHA to pay for non-VA providers: (1) when a clinical service cannot be provided at a VA medical center (VAMC); (2) when VA health care facilities are geographic inaccessibility to the veteran; or (3) in emergencies when delays could lead to life threatening situations.<sup>18</sup> These are generally referred to as Fee Basis Care services. Fee Basis Care may include dental services, outpatient care, inpatient care, emergency care, and medical

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<sup>12</sup> U.S. Department of Veterans Affairs, *FY 2009 Performance and Accountability Report*, Washington, DC, November 16, 2009, p. I-42. Established on January 3, 1946, as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

<sup>13</sup> Adam Oliver, "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly*, vol. 85, no. 1 (March 2007), pp. 5-35.

<sup>14</sup> Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA health care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*, vol. 38, no. 6 (June 2000), Suppl 1:I7-I16.

<sup>15</sup> For more information on CBOCs, see CRS Report R41044, *Veterans Health Administration: Community-Based Outpatient Clinics*, by Sidath Viranga Panangala.

<sup>16</sup> Vet Centers are a nationwide system of community-based programs separate from VA medical centers (VAMCs). Client services provided by Vet Centers include psychological counseling and psychotherapy (individual and group), screening for and treatment of mental health issues, substance abuse screening and counseling, employment/educational counseling, and bereavement counseling, among other services.

<sup>17</sup> U.S. Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2012, p. 1E-5.

<sup>18</sup> 38 U.S.C. §§1703, 1725, and 1728.

transportation. Pre-authorized inpatient services include non-emergency and emergency care.<sup>19</sup> Inpatient and outpatient care are also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).<sup>20</sup> The VHA also provides grants for construction of state-owned nursing homes and domiciliary facilities<sup>21</sup> and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

Apart from providing direct patient care to veterans,<sup>22</sup> VHA's other statutory missions are to conduct medical research,<sup>23</sup> serve as a contingency backup to the DOD medical system during a national security emergency,<sup>24</sup> provide support to the National Disaster Medical System and the Department of Health and Human Services as necessary,<sup>25</sup> and train health care professionals to provide an adequate supply of health personnel for the VA and the nation.<sup>26</sup>

## **The Veteran Patient Population<sup>27</sup>**

In FY2012, approximately 8.7 million of the 22.1 million living veterans in the nation were enrolled in the VA health care system.<sup>28</sup> It is estimated that in FY2013 there will be approximately 8.8 million veterans enrolled in the system. Of the total number of enrolled veterans in FY2012, VA anticipated treating approximately 5.6 million unique veteran patients.<sup>29</sup> For FY2013, VHA estimates that it will treat about 5.7 million unique veteran patients or 2.0% over the FY2012 estimate. Included within this estimate are 610,416 Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) veteran patients (9.7% of the total patient population) who VA anticipates treating in FY2013.

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<sup>19</sup> For detailed discussion of contracted care, see CRS Report R41065, *Veterans Health Care: Project HERO Implementation*, by Sidath Viranga Panangala.

<sup>20</sup> For details on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala.

<sup>21</sup> Under the grant program, VA may fund up to 65% of the cost of these state-owned facilities. States must fund the remaining 35%. The law requires that 75% of the residents in a state extended care facility must be veterans (38 U.S.C. §§8131-8138.) All non-veteran residents must be spouses of veterans or parents of children who died while serving in the U.S. armed forces. VA is prohibited by law from exercising any supervision or control over the operation of a state veterans nursing home, including setting admission criteria. Admission requirements are determined exclusively by the state.

<sup>22</sup> 38 U.S.C. §7301(b).

<sup>23</sup> 38 U.S.C. §7303.

<sup>24</sup> 38 U.S.C. §8111A.

<sup>25</sup> 38 U.S.C. §8117(e).

<sup>26</sup> 38 U.S.C. §7302.

<sup>27</sup> Data in this section adapted from Office of Management and Budget (OMB), *Appendix, Budget of the United States Government Fiscal Year 2013*, Washington, DC, February 13, 2012, pp. 1124-1135, and Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2012, p. 1B-4.

<sup>28</sup> In general, a veteran is required to be enrolled in the VA health care system to receive health care services, and once a veteran is enrolled, that veteran remains enrolled in the VA health care system and maintains access to VA health care services. For more information on enrollment, see <http://www.va.gov/healthbenefits/apply/>.

<sup>29</sup> An unique veteran patient means each patient is counted only once in each fiscal year. However, there could be multiple visits (clinical encounters) per unique veteran patient in a given fiscal year.



The VHA also estimates that outpatient visits will increase from 87.7 million in FY2012 to 91.1 million in FY2013, an increase of 3.3 million, or 3.8 %. It also anticipates an increase in inpatients treated from 919,487 in FY2012 to 936,201 in FY2013, an increase of 16,714, or 1.8%.

## President's Request

The VA's annual appropriations for the medical services, medical support and compliance, and medical facilities accounts, include advance appropriations that become available one fiscal year after the fiscal year for which the appropriations act was enacted. Therefore, funding levels for FY2013 for these three accounts were provided by the Consolidated Appropriations Act 2012 (P.L. 112-74).<sup>30</sup> However, in any given year the Administration could request additional funding for the upcoming fiscal year and Congress could revise these amounts through the annual appropriations process.

For FY2013, the President's budget is requesting \$41.5 billion for the medical services account. This amount is \$165 million over the FY2013 advance appropriated amount of \$41.4 billion. According to the VA,<sup>31</sup> this increase reflects the increased costs of the implementation of the Caregivers and Veterans Omnibus Health Services Act (P.L. 111-163) and the Agent Orange<sup>32</sup> and Amyotrophic Lateral Sclerosis (ALS) presumptions established by the VA.<sup>33</sup> For the medical support and compliance, and the medical facilities accounts, the President's FY2013 budget is proposing the same amount as the advance appropriated amount of \$5.7 billion and \$5.4 billion, respectively (see **Table 1**).

The President's budget is requesting approximately \$583 million for the medical and prosthetic research account, an increase of \$1.7 million, or 0.3%, above the FY2012 enacted amount of \$581 million. VHA's major research priorities in FY2013 will include, among others, mental health, Gulf War veterans' illnesses and exposures, prosthetics, traumatic brain injury (TBI), spinal cord injury, women veterans, and a special initiative on researching pain.<sup>34</sup>

In total the FY2013 budget request for VHA is \$56.3 billion, including medical care collections (see **Table 1**).

As required by the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81), the President's budget is requesting \$54.5 billion in advance appropriations for the three

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<sup>30</sup> See CRS Report R41944, *Veterans' Medical Care: FY2012 Appropriations*, by Sidath Viranga Panangala.

<sup>31</sup> U.S. Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Volume 2 of 4, February 2012, p. 1A-3.

<sup>32</sup> In August 2010, VA issued regulations establishing presumptive service connection for three new conditions: (1) B-cell leukemias, such as hairy cell leukemia; (2) Parkinson's disease; and (3) ischemic heart disease (see Department of Veterans Affairs, "Diseases Associated With Exposure to Certain Herbicide Agents (Hairy Cell Leukemia and Other Chronic B-Cell Leukemias, Parkinson's Disease and Ischemic Heart Disease)," *75 Federal Register* 53202-53216, August 31, 2010). This rule change resulted in an increase in service-connected patients and added new patients to VA's health care system. Furthermore, it changed the priority levels of veterans currently enrolled in VA's health care system.

<sup>33</sup> In 2008, the VA, through regulation, established a presumptive service connection for ALS, making those veterans with ALS eligible for free health care for symptoms associated with ALS (see Department of Veterans Affairs, "Presumption of Service Connection for Amyotrophic Lateral Sclerosis," *73 Federal Register* 54691-54693, September 23, 2008). To be eligible for this presumptive service connection, a veteran must have served on continuous active duty for a period of 90 days or more. For more information on presumptive service connection, see CRS Report R41405, *Veterans Affairs: Presumptive Service Connection and Disability Compensation*, coordinated by Sidath Viranga Panangala.

<sup>34</sup> U.S. Office of Management and Budget (OMB), *Appendix, Budget of the United States Government Fiscal Year 2013*, Washington, DC, February 13, 2012, pp. 1129.



medical care appropriations (medical services, medical support and compliance, and medical facilities) for FY2014, an increase of approximately 3.3% over the FY2013 requested amount of \$52.7 billion for the same three accounts. In FY2014, the Administration's budget request would provide \$43.6 billion for the medical services account, \$6.0 billion for the medical support and compliance account, and \$4.9 billion for the medical facilities account (see **Table 1**).

**Table 1. Veterans Health Administration (VHA) Budget Authority by Account, FY2011-FY2013 and Advance Appropriations, FY2014**

(dollars in thousands)

Account	FY2011	FY2012	FY2013 Request	FY2014 Advance Funding <sup>a</sup>
Medical services	\$36,948.2	\$39,462.2	\$41,504.0 <sup>b</sup>	\$43,600.0
Medical support and compliance	5,252.4	5,510.8	5,746.0 <sup>c</sup>	6,000.0
Medical facilities	5,703.1	5,388.8	5,441.0 <sup>d</sup>	4,900.0
Medical and prosthetic research	579.8	581.0	582.7	0.0
Subtotal, VHA	48,483.6	50,942.9	53,273.7 <sup>e</sup>	54,500.0
DOD-VA Health Care Sharing Incentive Fund <sup>f</sup>	130.0	30.0	30.0 <sup>g</sup>	0.0
DOD-VA Medical Facility Demonstration Fund	104.0	258.3	0.0	0.0
MCCF	2,770.7	2,749.4	2,966.0	0.0
<b>Total, Medical w/ collections</b>	<b>51,488.2</b>	<b>53,980.6</b>	<b>56,269.7<sup>h</sup></b>	<b>54,500.0</b>

**Source:** Table prepared by the Congressional Research Service (CRS) based on Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Volume 1 of 4, Feb. 2012, p. 1B-1.

- a. The Veterans Health Care Budget Reform and Transparency Act of 2009, P.L. 111-81, requires VA to submit a request for advance appropriations with its budget submission each year for the medical services, medical support and compliance, and medical facilities accounts.
- b. Of this amount, \$41.3 billion was appropriated as an advance appropriation in the Consolidated Appropriations Act 2012 (P.L. 112-74). This amount also reflects the transfer of \$15 million to the DOD-VA Health Care Sharing Incentive Fund.
- c. This amount was appropriated as an advance appropriation in the Consolidated Appropriations Act 2012 (P.L. 112-74).
- d. This amount was appropriated as an advance appropriation in the Consolidated Appropriations Act 2012, P.L. 112-74.
- e. Of this amount, \$52.5 billion was appropriated as an advance appropriation in the Consolidated Appropriations Act 2012, P.L. 112-74.
- f. Section 721 of the FY2003 National Defense Authorization Act (P.L. 107-34) established the Department of Defense-Veterans Affairs Health Care Sharing Incentive Fund to enable the departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional and nationwide levels. Each department contributes \$15 million toward the fund.
- g. This amount reflects the transfer of \$15 million from the medical services account and \$15 million from the Department of Defense (DOD).
- h. Of this amount, \$41.3 billion was appropriated as an advance appropriation in the Consolidated Appropriations Act 2012 (P.L. 112-74). This amount also reflects the transfer of \$15 million to the DOD-VA Health Care Sharing Incentive Fund.

## The Budget Request for FY2013—Mandatory Benefit Programs and Administration

**Table 2** shows the VA budget for mandatory benefit programs and administration as reported by the VA for FY2011 through FY2013. The changes in certain accounts between FY2011 and FY2013 may reflect changes due to law, regulations, or other factors as discussed below.

**Table 2. Department of Veterans Affairs (VA) Budget Authority by Account, FY2011-FY2013, Mandatory Benefits and Administration**

(dollars in thousands)

Account	FY2011	FY2012	FY2013 Request
Compensation and pensions	\$53,039.7	\$51,237.6	\$61,741.2
Readjustment benefits	11,334.6	12,108.5	12,607.5
Insurance (mandatory)	77.6	100.3	104.6
Housing and other mandatory benefits	1,387.4	1,658.7	184.9
Veterans Employment & Infrastructure Enhancement Transfer Fund	N.A.	N.A.	1,000.0
Non-appropriated accounts	539.4	615.6	729.7
<b>Total, Mandatory Benefits</b>	<b>66,378.6</b>	<b>65,720.7</b>	<b>76,367.9</b>
General Operating Expenses - VBA	2,132.5	2,018.8	2,164.1
General Administration	396.7	416.7	416.7
National Cemeteries Administration	249.5	250.9	258.3
Information Technology	2,991.6	3,104.8	3,327.4
Office of the Inspector General	108.8	112.4	113.0
Major Construction	1,073.7	589.6	532.5
Minor Construction	466.8	482.4	607.5
Grants for Extended Care Facilities	84.8	85.0	85.0
Grants for State Cemeteries	45.9	46.0	46.0
Credit Reform	162.9	156.2	159.3
<b>Total, Administration</b>	<b>7,713.2</b>	<b>7,262.8</b>	<b>7,709.8</b>

**Source:** Table prepared by the Congressional Research Service (CRS) based on Department of Veterans Affairs, *FY2013 Budget Submission, Medical Programs and Information Technology Programs*, Vol. 1 of 4, February 2012, p. 1B-1.

**Notes:** N.A. = Not applicable. New program (legislative proposal) for FY2013.

## Disability Compensation

The Disability Compensation category includes payments for a number of benefits, such as disability compensation; dependency and indemnity compensation (DIC); pension benefits for low-income disabled or elderly combat veterans and their survivors; burial benefits (allowances, flags, headstones, etc.); and a clothing allowance for certain disabled veterans.

The large increase (\$10.5 billion, or 20.5%) between FY2012 and FY2013 is overstated due to the impact of carryovers (unobligated balances). There was a large carryover between FY2011

and FY2012 of \$12.9 billion, of which \$9.9 billion is anticipated to be obligated in FY2012 (for a total obligation in FY2012 of \$61.2 billion), leaving a carryover of \$3.0 billion into FY2013. The carryover has been the result of lower than anticipated retroactive payments associated with the recent presumptions related to Agent Orange. In general, the average payments for benefits, including disability compensation, pension, and survivor benefits are expected to increase due to the annual cost-of-living adjustment (COLA).

## **Readjustment Benefits**

The Readjustment Benefits category reflects a number of benefits related to the transition of servicemembers from active duty status to veteran status, as well as disabled veterans, including education benefits, vocation rehabilitation, financial assistance for adaptive automobiles and equipment, and housing grants.

The increase in readjustment benefits between FY2012 and FY2013 reflects increases in two programs: (1) the Post-9/11 GI bill (primarily due to the COLA) and (2) the Veterans Retraining Assistance Program that was established by P.L. 112-56.

## **Insurance (Mandatory)**

The Insurance (Mandatory) category includes supplemental funding for National Service Life Insurance (NSLI),<sup>35</sup> Service-Disabled Veterans Insurance (S-DVI),<sup>36</sup> and Veterans Mortgage Life Insurance (VMLI).

The increase between FY2012 and FY2013 for insurance reflects the deaths associated with the NSLI and S-DVI programs and the increase in the maximum coverage under the VMLI program.

## **Housing and Other Mandatory Benefits**

The Housing and Other Mandatory Benefits category includes guaranteed and direct loan programs for veterans, Native American housing loans, and various proprietary receipts (from the public).

The decrease in the mandatory housing category between FY2012 and FY2013 reflects the timing of the re-estimates for the programs. The FY2013 re-estimates will not be completed until the end of FY2012 and will be reflected in the FY2014 budget submission. Because of the timing of the re-estimates, the FY2012 housing category is \$1.3 billion higher than the original budget submission.

## **Veterans Employment and Infrastructure Enhancement Transfer Fund**

This is a new category reflecting a proposal for legislation to create a Veterans Job Corps.

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<sup>35</sup> The National Service Life Insurance (NSLI) program was open for new policies between October 8, 1940, and April 24, 1951. NSLI provided a maximum of \$10,000 in coverage. Veterans may be covered under five-year term or permanent policies.

<sup>36</sup> The Service-Disabled Veterans Insurance (S-DVI) program opened April 25, 1951, and remains open for new policies to disabled veterans meeting certain requirements. S-DVI provides up to \$10,000 in coverage for which premium relief can be provided to certain insured veterans, and up to \$30,000 in supplemental coverage (no premium relief).

## **General Operating Expenses—VBA**

The increase in the VBA general operating expenses between FY2012 and FY2013 is primarily due to an increase in personal services costs, associated with personnel and the proposed cost-of-living adjustment.

## **Information Technology**

The Information Technology category includes maintenance and improvements to the information technology of all VA functions. For FY2013, the Administration's budget requests \$3.3 billion for Information Technology, an increase of \$216 million over the FY2012 enacted level of \$3.1 billion.

## **Major Construction**

The Major Construction category, which is for construction related projects for all VA components in which the total project cost is \$10 million or more, reflects a decrease of 9.7% between FY2012 and FY2013.

## **Minor Construction**

The Minor Construction category, which is for construction related projects for all VA components in which the total project cost is less than \$10 million, reflects an increase of 25.9% between FY2012 and FY2013.

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